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7/6/06 CAC

Commonwealth of Massachusetts—Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for a substantial period of time and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts.

PHOTOGRAPH



R. Badgarian
Signature of applicant

I certify that the photograph above is a genuine likeness of the maker of the signature above.

W. J. Fischman
Signature of Notary

1/13/2006
My commission expires

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

Rajendra D. Badgarian
(name of applicant)

for 5 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Alan J. Fischman
Signature of Certifying Physician

56574
License Number

MA
State

ALAN J. FISCHMAN
Type or print name clearly

Address Massachusetts Gen Hospital

City Boston

State MA

Zip 02114

Telephone (617) 726-8353

Date 2/2/04

Instructions to the certifying physician: Return the completed form to the applicant in a sealed envelope with your signature across the seal.

Seal Verified
DATE: 05/02/04
INITIALS: JD

BRM0054

Application #
Date of Issue

220501

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Commonwealth of Massachusetts Board of Registration in Medicine
Harrison Avenue, Suite #G4, Boston, MA 02118 (617) 654-9810 - www.massmedboard.orgFULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of \$600.00 made payable to the Commonwealth of Massachusetts.

Check One:

☐ U.S./Canadian Graduate☒ International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name):

BADGAIYAN RAJENDRA DHAR
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)☒ M.D. ☐ D.O. ☐ Ph.D. ☐ Other degree MB, BS ☒ Male ☐ FemaleOther Name(s) Used: List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☐

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: 07/14/55
Month Day Year

Social Security Number: 544-45-6718

Place of Birth: Raigarh Chhattisgarh India
City State/Province/Territory Country if not USAHome Address: 122-A Sycamore Street
Somerville MA 02145
City State/Province/Territory Zip (or postal) CodeBusiness Address: 55 Fruit Street (Massachusetts General Hospital)
Boston MA 02114
City State/Province/Territory Zip (or postal) Code

Business Telephone: (617) 724-1793 ext. Home Telephone: (617) 623-1140

Preferred Mailing Address: ☐ Business Address ☒ Home Address

BRM0055

SUPPLEMENT FORM

PRINT NAME: Rajendra Dhar Badgarian DATE: 1/29/03

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

- | | <u>YES</u> | <u>NO</u> |
|--|-------------------------------------|-------------------------------------|
| 1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition). | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

PRINT NAME: _____

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- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 9-A. Have you ever voluntarily relinquished any medical staff membership? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been charged with any criminal offense, other than a minor traffic offense? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13. Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15-B. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Applicant's Signature: _____

R. Badgerman

Date: 1/29/03

BRM0057

PRINT NAME: Rajendra D. Badgarian

PAGE 3 OF 3

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

Please see attached sheet - Page 3A and 3B
From To

Facility: _____ Position: _____ / / / /
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
 Street: _____ City: _____ State: _____

1. List other states (abbreviations) where you are currently or have ever been licensed: None

2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No

3. List Board Certification(s): _____ Certification date: _____ / /

_____ Certification date: _____ / /

4. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No

5. Reason for requesting a Massachusetts medical license: Plan to practice
in Massachusetts (Massachusetts General Hospital)

6. Name of Facility: Massachusetts General Hospital

7. Address: 55 Fruit Street City: Boston, MA 02114

8. Anticipated starting date in Massachusetts: 5/1/04

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

R. Badgarian
 Signature of Applicant

1/29/04
 Date

Page 3A

Hospital Affiliations and Employment (Continued from page 7)

Facility and Address	Position	From	To
Institute of Medical Sciences, Banaras Hindu University, Varanasi 221005, India	Lecturer	3/29/86	2/8/92
Institute of Medical Sciences, Banaras Hindu University, Varanasi 221005, India	Reader	2/9/92	5/31/95
University of Oregon, 1227 UO Campus Eugene, OR 97403	Research Associate	6/1/95	9/15/96
University of Texas, 6900 North Loop 1604 West, San Antonio TX 78249	Lecturer	9/16/96	12/31/96
Western Psychiatric Institute and Clinic Univ of Pittsburgh Medical Center, 3811 Ohara St, Pittsburgh, PA 15213	Post-doctoral Fellow	1/1/97	3/31/98
Department of Psychology, Harvard Univ 33, Kirkland St, Cambridge MA 02138	Post-doctoral Fellow	4/1/98	4/30/99
Department of Psychology, Harvard Univ 33, Kirkland St, Cambridge MA 02138	Research Associate	5/1/99	6/30/01
VA Medical Center, 940 Belmont St Brockton, MA 02301	Resident	10/19/99	12/31/03
Harvard Medical School VA Med Center 940 Belmont Street Brockton, MA 02301	Clinical Fellow	10/19/99	6/30/01
Department of Radiology, Massachusetts General Hospital, 55 Fruit St, Boston MA 02114	Assistant neuroscientist	2/5/01	till date
Department of Radiology, Massachusetts General Hospital, 55 Fruit St, Boston MA 02114	Assistant Professor	7/1/02	till date

R. B. Saper 3/4/2004

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Page 3A

Hospital Affiliations and Employment

Facility and Address	Position	From	To
Gandhi Medical College and Hamidia Hospital, Royal Market, Bhopal 462001, India	Intern	5/1/78	4/30/79
Gandhi Medical College, and Hamidia Hospital, Royal Market, Bhopal 462001, India	Demonstrator	9/21/79	1/20/84
Medical College, Rohtak, (Haryana) India	Assistant Professor	1/21/84	3/28/86
Institute of Medical Sciences, Banaras Hindu University, Varanasi 221005, India	Lecturer	3/29/86	2/8/92
Institute of Medical Sciences, Banaras Hindu University, Varanasi 221005, India	Reader	2/9/92	5/31/95
University of Oregon, 1227 UO Campus Eugene, OR 97403	Research Associate	6/1/95	9/15/96
University of Texas, 6900 North Loop 1604 West, San Antonio TX 78249	Lecturer	9/16/96	12/31/96
Western Psychiatric Institute and Clinic Univ of Pittsburgh Medical Center, 3811 Ohara St, Pittsburgh, PA 15213	Post-doctoral Fellow	1/1/97	3/31/98
Department of Psychology, Harvard Univ 33, Kirkland St, Cambridge MA 02138	Post-doctoral Fellow	4/1/98	4/30/99
Department of Psychology, Harvard Univ 33, Kirkland St, Cambridge MA 02138	Research Associate	5/1/99	6/30/01

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Page 3B

VA Medical Center, 940 Belmont St
Brockton, MA 02301

Resident

10/19/99 12/31/03

Harvard Medical School VA Med Center
940 Belmont Street
Brockton, MA 02301

Clinical Fellow

10/19/99 6/30/01

Department of Radiology, Massachusetts
General Hospital, 55 Fruit St,
Boston MA 02114

Assistant neuroscientist

2/5/01

till date

Department of Radiology, Massachusetts
General Hospital, 55 Fruit St,
Boston MA 02114

Assistant Professor

7/1/02

till date

R. B. DeSage
1/29/04

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PRINT NAME: R. D. Badganyan PAGE 2 OF 3**Pre-medical School**

Facility: Saugar University Degree: Pre Med From 7/1/71 To 4/30/72
 Street: UTD City: Sagar State: M.P. (India)

Facility: Kendriya Vidyalyaya Degree: HSE (Biology) From 7/1/70 To 4/30/71
 Street: Cantt. City: Sagar State: M.P. India

Medical School

Facility: Gandhi Medical College Degree: MBBS From 8/1/72 To 4/30/78
 Street: Royal Market City: Bhopal-462001 State: M.P. (India)

Facility: Gandhi Medical College Degree: MD From 9/1/79 To 10/1/82
 Street: Royal Market City: Bhopal-462001 State: M.P. (India)

Date of medical school graduation: 4/30/1978 - MBBS
10/1/1982 - MD

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: VA Medical Center Position: PGY I-IV From 10/19/99 To 12/31/03
 Street: 940, Belmont St. City: Brockton State: MA

Facility: _____ Position: _____ / / / /
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
 Street: _____ City: _____ State: _____

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 U.S. DEPARTMENT OF
 HEALTH & HUMAN SERVICES
 IN MEDICINE

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PRINT NAME: R. D. Badgayan PAGE 2 OF 3Pre-medical School

Facility: Sangar University Degree: Pre Med From 7/1/71 To 4/30/72
 Street: UTD City: Sagar State: M.P. (India)

Facility: _____ Degree: _____ From _____ To _____
 Street: _____ City: _____ State: _____

Medical School

Facility: Gandhi Medical College Degree: MBBS From 8/1/72 To 4/30/78
 Street: Royal Market City: Bhopal-462001 State: M.P. (India)

Facility: Gandhi Medical College Degree: MD From 9/1/79 To 10/1/82
 Street: Royal Market City: Bhopal-462001 State: M.P. (India)

Date of medical school graduation: 4/30/1978

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: VA Medical Center Position: PGY I-IV From 10/19/99 To 12/31/03
 Street: 940, Belmont St. City: Brockton State: MA

Facility: _____ Position: _____ From _____ To _____
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ From _____ To _____
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ From _____ To _____
 Street: _____ City: _____ State: _____

Facility: _____ Position: _____ From _____ To _____
 Street: _____ City: _____ State: _____

SUPPLEMENT FORM

PRINT NAME: Rajendra D. Badgarian DATE: 4/26/04

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

- | | <u>YES</u> | <u>NO</u> |
|--|-------------------------------------|-------------------------------------|
| 1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition). | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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PRINT NAME: Rajendra D. Badgayan PAGE 3 OF 3**Hospital Affiliations and Employment**

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary. (See attached sheet)

	From	To
Facility: <u>Gandhi Medical College</u> Position: <u>Intern</u>	<u>5/1/78</u>	<u>4/30/79</u>
Street: <u>Royal Market</u> City: <u>Bhopal</u> State: <u>M.P., India</u>		
Facility: <u>Gandhi Medical College</u> Position: <u></u>	<u>7/1/79</u>	<u>9/20/79</u>
Street: <u>Royal Market</u> City: <u>Bhopal</u> State: <u>M.P., India</u>		
Facility: <u>Gandhi Medical College</u> Position: <u>Demonstrator</u>	<u>9/21/79</u>	<u>1/20/84</u>
Street: <u>Royal Market</u> City: <u>Bhopal</u> State: <u>M.P., India</u>		
Facility: <u>Medical College</u> Position: <u>Assistant Prof.</u>	<u>1/21/84</u>	<u>3/28/86</u>
Street: <u>Model Town</u> City: <u>Rohatak</u> State: <u>Haryana, India</u>		

CONTINUED ON ATTACHED PAGE 3A

- List other states (abbreviations) where you are currently or have ever been licensed: None
- Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
- List Board Certification(s): N/A Certification date: / /
Certification date: / /
- Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
- Reason for requesting a Massachusetts medical license: Plan to practice
in Massachusetts.
- Name of Facility: Massachusetts General Hospital
- Address: 55, Fruit Street City: Boston, MA 02114
- Anticipated starting date in Massachusetts: 5/1/04

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

R. Badgayan
Signature of Applicant

3/4/2004.
Date

Page 7

PRINT NAME: Rajendra D. Badgarian**QUESTIONS #1, 8A, 8B – Disciplinary actions**

Attach additional pages with same format where more than one action was taken or is pending, and where otherwise necessary.

Name of agency or institution taking action: _____ Date: ____/____/____

Description: _____

_____You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the disciplinary action directly to the Board.**QUESTION #2 – Medical school and medical training program**

Attach additional pages with same format where necessary.

Name of institution: _____ Date of action: ____/____/____

Address: _____ City: _____

State: _____ Zip: _____ Dates of attendance: From: ____/____/____ To: ____/____/____

Description of events: _____

_____You must arrange for the appropriate agency or institution to submit all official documentation and correspondence regarding any termination, leave of absence, withdrawal, failure to complete or requirement to repeat directly to the Board.**QUESTION #4 & 5 – Examination failure; denial, improper conduct**

Attach additional pages with same format where necessary.

Name of organization: USMLE Name of exam: _____Action: Failed. I failed USMLE examination Date of Action: ____/____/____on the following dates because I took the tests while working full time as a researcher and was not adequately prepared.PLEASE SEE ATTACHED SHBBT (Page 7A) for details of failuresYou must arrange for the appropriate agency or institution to submit all official documentation and correspondence regarding any examination, restriction or other examination abnormality directly to the Board.Signature: R BadgarianDate: 3 / 4 / 2004

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QUESTION #4 & 5 – Examination failure; denial, improper conduct
Details of failure in USMLE examinations

Name of organization: USMLE
Action: Failed

Name of exam: Step 1
Date of exam: 5/11/1997

Name of organization: USMLE
Action: Failed

Name of exam: Step 2
Date of exam: 3/4/1997

Name of organization: USMLE
Action: Failed

Name of exam: Step 3
Date of exam: 12/1/1998

Name of organization: USMLE
Action: Failed

Name of exam: Step 3
Date of exam: 5/11/1999

Name of organization: USMLE
Action: Failed

Name of exam: Step 3
Date of exam: 4/22/2002

Name of organization: USMLE
Action: Failed

Name of exam: Step 3
Date of exam: 5/17/2003

Signature: _____

R. Badgerman

Date: 3/4/2004

Page 7

PRINT NAME: Rajendra D. Badgarian**QUESTIONS #1, 8A, 8B – Disciplinary actions**

Attach additional pages with same format where more than one action was taken or is pending, and where otherwise necessary.

Name of agency or institution taking action: Harvard South Shore Date: 5/1Description: Residency program
Put on probation (Please see my letter of
April 26, 2004 for details).You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the disciplinary action directly to the Board.**QUESTION #2 – Medical school and medical training program**

Attach additional pages with same format where necessary.

Name of institution: _____ Date of action: ____/____/____

Address: _____ City: _____

State: _____ Zip: _____ Dates of attendance: From: ____/____/____ To: ____/____/____

Description of events: _____

You must arrange for the appropriate agency or institution to submit all official documentation and correspondence regarding any termination, leave of absence, withdrawal, failure to complete or requirement to repeat directly to the Board.**QUESTION #4 & 5 – Examination failure; denial, improper conduct**

Attach additional pages with same format where necessary.

Name of organization: USMLE Name of exam: _____Action: Failed. I failed the USMLE Date of Action: ____/____/____examinations on the dates mentioned in the
attached sheet because I took the tests while working
full time and was not adequately prepared.PLEASE SEE ATTACHED SHEET (Page 7A) for details.
You must arrange for the appropriate agency or institution to submit all official documentation and correspondence regarding any examination, restriction or other examination abnormality directly to the Board.Signature: R Badgarian Date: 4/28/04

BRM0068

Rajendra D. Badgaiyan, MD
Assistant Professor, Harvard Medical School
Massachusetts General Hospital, Boston, MA 02114
E-mail: rajendra@wjh.harvard.edu

April 26, 2004

Rose M Foss,
Director of Licensing
Commonwealth of Massachusetts Board of registration in Medicine
Boston, MA 02118

Dear Ms Foss,

I thank you for the letter of April 21, 2004 in which you have asked me to provide additional information. The information requested are briefly summarized in the following paragraphs:

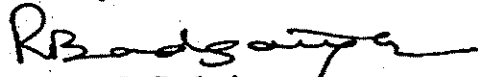
1. I have enclosed an amended supplement form that reflects the report you received from the Director of the Residency Training Program. I am sorry for the inconsistency between my original application and the Director's report regarding the probation. I was under the impression that I was never officially put on probation. I never received any official letter (which is the usual practice) to suggest that I was on probation. I did however receive an informal e-mail (during the PGY-2 year) in which among other things, the director had casually mentioned the probation. Because the e-mail did not mention the period of probation, the remedial actions that I was supposed to take, and whether it was approved by the promotions committee, I believed that it was not an official communication. In addition, after an informal mediation, a VA alternate dispute resolution specialist (Ms Patricia Riley) indicated (in or around May of 2003) that all adverse entries in my record would be removed. As a confirmation, I received the graduation certificate in December 2003, even though the 'probation' was never revoked. I therefore had reasons to believe that the official records do not indicate that I was ever on probation. This belief obviously was wrong. I am sorry about it, and as suggested, I have enclosed an amended supplement form. To avoid this situation, I have requested the program director (at least twice) to allow me access to the training records and the preceptor/supervisors' evaluations so that I am aware of the official status.
2. In July of 2002, I briefly became anxious and sad for various reasons. I therefore had an hour-long clinical consultation with a psychiatrist, Dr Carl Salzman, MD. He advised me to consider taking a short course of an antidepressant medication if the symptoms persist. He gave me a prescription and a referral to another psychiatrist, in case I needed them. I however never used the referral or the prescription because my symptoms improved within a few days. I would like to mention that many residents of the program had similar symptoms at that time, and at least four of the other five residents of my class had to seek counseling during the training. In the same year, in a nationally conducted test of clinical knowledge and skill (PRITE), my performance was the best in the class. Even though I took the test as a PGY-2 resident, I was one of the 4 best performers of the entire residency program.

I have requested Dr Carl Salzman, MD to send you a letter concerning the consultation.

3. As discussed, I have enclosed an evaluation form that I received in a sealed and signed envelope from Dr Lewis Kirshner MD, who is a senior staff psychiatrist at the VA Medical Center Brockton, and an Associate Professor of Psychiatry at Harvard Medical School. He supervised my clinical work during the residency training at the VA Medical Center.
4. I believe you have received my evaluations from the program director. I have not seen most of them, but was able to obtain copies of some of the evaluations directly from the preceptors. These evaluations are enclosed.

I hope this letter answers the questions asked.

Sincerely,



Rajendra D. Badgaiyan
122A Sycamore Street, Somerville, MA 02145
Phone: 617-623-1140; 617-504-6780 (Cell)

QUESTION #4 & 5 – Examination failure; denial, improper conduct
Details of failures in the USMLE examinations

Name of organization: USMLE
Action: Failed

Name of exam: Step 1
Date of exam: 5/11/1997

Name of organization: USMLE
Action: Failed

Name of exam: Step 2
Date of exam: 3/4/1997

Name of organization: USMLE
Action: Failed

Name of exam: Step 3
Date of exam: 12/1/1998

Name of organization: USMLE
Action: Failed

Name of exam: Step 3
Date of exam: 5/11/1999

Name of organization: USMLE
Action: Failed

Name of exam: Step 3
Date of exam: 4/22/2002

Name of organization: USMLE
Action: Failed

Name of exam: Step 3
Date of exam: 5/17/2003

Signature: R. Badgley Date: 4/26/04